Statewide Transformation Initiative Mental Health Benefit Package Design Final Report – Analysis and Recommendations for Tribal Governments and their Members

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Analysis and Recommendations for Tribal Governments and their Members

Overview of Relationships Between MHD and Sovereign Tribes in the State of Washington

The basis of the relationship between the government agencies of the State of Washington and the 29 federally recognized Tribes in Washington State is the Centennial Accord signed in August, 1989. The Accord provides a framework for government to government relationships between the State of Washington and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognized the "chief representatives of all elements of state government" to ensure complete and broad implementation of the arrangement. The Mental Health Division (MHD), as part of the Department of Social and Health Services (DSHS), thereby maintains a direct working relationship with each of the 29 Tribes.

Members of the 29 federally recognized Tribes in Washington State are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid PIHP administered by the RSNs, or a combination of these systems. Given these multiple systems, MHD and each of the 29 Tribes must coordinate activities at multiple levels. While the primary relationship is between each Tribe and the State of Washington, on a day-to-day basis various agents acting on behalf of the State of Washington, including RSNs and state-operated treatment facilities such as the State Hospitals and CLIP facilities, all must coordinate their activities with each individual Tribe.

Coordination across these systems is supported through the 7.01 planning and policy development process, through which an overall Updated Report is renewed every two years to coordinate the efforts of DSHS overall, DMH, and the RSNs. Each of the 13 RSNs contracting with MHD are also required to carry out 7.01 planning at a local level with the Tribes located within their geographical boundaries. Coordination is critical, given differences between Tribes in terms of their resources, needs and the services they provide, as well as differences in their relationships with DSHS, DMH, and local RSNs.

MHD also provides two regular forums for coordinating system issues related to the delivery of mental health services through Tribal providers and for Tribal members. The first forum is a monthly Tribal Mental Health Work Group that addresses a broad range of coordination issues. The second is a Tribal Billing Instructions Work Group that addresses issues related to encounter reporting and reimbursement.

Methodology and Approach

There were multiple sources of information drawn upon in developing this chapter. First, input was sought directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers. Initial input was obtained through a Tribal Forum held in February 2007.

Based on input from that Forum, two focus groups were carried out in April 2007 involving a broader representation of Tribal Governments, RAIOs, and IPSS managers. One group was held in eastern Washington at the American Indian Health Center in Spokane, Washington. The group involved representatives from three eastern Washington Tribes (Colville Confederated Tribes, Kalispel Tribe, and Confederated Tribes of the Yakama Nation), five representatives from RAIOs, and two IPSS staff. The second group was held in western Washington and involved the Tribal Chairman of the Stillaguamish Tribe, other representatives from seven western Washington Tribes (Makah Nation, Puyallup Tribe, Shoalwater Bay Tribe, Skokomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe), and two IPSS staff. In addition, we conducted follow-up interviews with interested focus group participants, as well as interviews with the MHD Tribal Liaison. We also conducted additional targeted legal research regarding how other states involve Tribal Providers within their managed care delivery systems, focusing on Arizona (an optional Public Law 83-280 state like Washington) and New Mexico (a non-P.L. 280 state).

Tribal Issues Identified Related to Benefit Design

Through the focus groups, additional interviews with Tribal representatives, IPSS staff, and MHD staff, the following issues were identified as unique to MHD's relationships with Tribal Governments, Tribal providers, and services to Tribal members.

Recognition of the complexity of Tribal mental health systems. One key observation across both focus groups and our regulatory review is that Tribal mental health systems are a distinct part of the public mental health system that are both different and more complex in their regulatory requirements than non-Tribal mental health systems. While RSNs must comply with federal and state regulations through MHD, Tribal providers operate in a system with the additional complexity of direct relationships between Tribes and the State, as well as Tribes and the federal government.

One example noted in the focus groups was the regulations whereby Tribal members are entitled to receive services from multiple systems: Tribal providers, IHS or 638 facilities, RAIOs, and non-Tribal CMHA providers within RSN networks. This was seen as complicating service delivery, resulting in confusion at the administrative level, a frequent response that "someone else" was responsible for providing care, and, to some degree, increased confusion on the part of Tribal members as they seek to access care.

Lack of clarity regarding the role of Tribal providers. Focus group participants clearly articulated a current lack of clarity regarding the role of Tribal providers in the broader public mental health system, and particularly their involvement in RSN networks. Some of this lack of clarity reflects the multiple ways in which Tribes may choose to organize their health services. Tribal providers delivering Medicaid mental health services may choose between fee for service reimbursement using the federal encounter rate or participation in RSN provider networks. However, the lack of clarity seemed also to stem from different interpretations by different RSNs working with Tribes in their geographic areas.

Significant concern was expressed in the focus groups regarding the issue of whether or not Tribal providers were required to be licensed as Community Mental Health Agencies (CMHAs) prior to participation in RSN networks. The June 2006 HRSA Tribal Health Program Billing Instructions clearly define how Tribes may choose between the following designations for their health providers:

- Designation as IHS or Tribal 638 facilities paid the federal IHS encounter rate,
- Tribal facilities paid under the state's fee for service system, or
- Tribal federally qualified health clinics (FQHCs).

The manual is also clear about the choice that Tribal members have between receiving mental health services through RSNs or directly through IHS or Tribal 638 facilities or through both systems. These facilities may also provide services to non-Tribal members under the "clinical family" definition (which is discussed in more detail later in this chapter).

What is not clear in this manual or other Washington State documentation we reviewed is the manner in which IHS and Tribal 638 providers may participate in RSN networks. Federal law governing the Medicaid program (42 CFR 431.110) clearly states that IHS facilities are not subject to state licensure to qualify for Medicaid participation and "must be accepted as a Medicaid provider on the same basis as any other qualified provider." The requirement goes on to state that, while "the facility need not obtain a [State] license," it nevertheless "must meet all applicable standards for licensure."

Consistent with this requirement, a state may require their managed care organizations (entities analogous in role to RSNs in those states) to involve IHS and Tribal 638 facilities directly in their managed care provider networks without additional licensure. For example, New Mexico's regulations governing its managed care provider networks require the extension of network participation to IHS and Tribal 638 facilities, as well as properly credentialed RAIOs. In New Mexico, mental health waiver and other mental health services are delivered by a single managed care organization (MCO) referred to as the "Statewide Entity" or "SE." While New Mexico's program operates on a statewide rather than a regional basis, the SE is analogous to Washington's RSN designation. The administrative requirements for the SE state: "The MCO/SE shall enter into contracts with 'essential' providers that include, but are limited to, IHS, 638 tribal programs and providers serving particular linguistic or cultural groups."[1] Accordingly, New Mexico incorporates the following requirement into its current MCO/SE contract: "The SE shall maintain contracts with IHS of Albuquerque and Navajo Area IHS and with 638, Tribal, Nation, Pueblo and Urban Indian behavioral health providers that meet minimal credentialing requirements for service delivery within New Mexico who want to contract with the SE."[2] It is important to note that, while Tribal providers are recognized as a distinct provider type for network participation (not subject to other state-level licensing requirements), they are still subject to the same minimal credentialing requirements as any other network provider.

[1] New Mexico Administrative Code 8.305.6.15(E)
[2] 2007 State of New Mexico Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract, Section 3.16.L

However, New Mexico's current 1915-b Waiver put the burden of effort to involve Tribal providers primarily on the SE, rather than the Tribes, as seen in the following excerpt:

> Native American providers such as Indian Health Service (IHS), tribal providers and 638 providers designated by the tribes will be considered essential providers with whom the SE will be obligated to contract so long as they can be credentialed for the services they provide and they want to contract with the SE. Credentialing of IHS and Tribal 638 facilities should take into account federal standards for licensure as well as special cultural issues associated with Native American providers, whether Tribal, federal or urban Indian. While credentialing offers a degree of assurance about quality of providers, the SE's single credentialing process may be difficult for some Native American providers and practitioners. The SE will be asked to take this into account and adjust the credentialing process accordingly. (New Mexico's January 27, 2007 Section 1915-B Waiver Proposal, page 6)

Arizona takes a different approach. As in Washington, IHS and Tribal 638 facilities may have direct fee for service payment relationships with the State, and, if so, their services are not reimbursed by Regional Behavioral Health Authorities (RHBAs), which is Arizona's equivalent entity to Washington's RSNs. However, Arizona also offers Tribes the opportunity to operate their own Tribal RBHAs, which provide either a full or partial range of RHBA services. Some Tribes (Gila River Indian Community and Pascua Yaqui Tribe) operate full RHBAs, subject to the same requirements as any other RHBA, and others (Navajo Nation, Colorado River Indian Tribes) operate partial RHBAs that allow them to provide a range of additional mental health services, such as case management. The T-RHBA designation allows Tribes in Arizona the ability to provide services under the broader waiver authority allowed for RBHAs, in addition to or instead of direct fee for service arrangements.

Washington State does not offer RSNs such definitive guidance for the involvement of Tribal providers. While the written Tribal coordination plans that are required offer an important basis for collaboration between Tribes and RSNs, there does not seem to be either a specific requirement (like New Mexico) that RSNs involve willing Tribal providers in their networks (regardless of CMHA licensure, but subject to minimum credentialing requirements) or a specific exclusion (like Arizona) that puts Tribal providers outside of the RSN system independently under a managed care waiver. The 2006 Washington Mental Health Transformation Plan: Phase 1 recognized this lack of clarity when it recommended that: "License/certification criteria needs to be changed to deem Tribally certified professionals and facilities as eligible to be reimbursed for services, including where desired, direct state contracts."[3]

Tribal providers serving non-Tribal members. Focus group participants also discussed the need for clarity regarding the limits for service provision by Tribal providers to non-Tribal members residing on or contiguous to Tribal land. The definition of a "clinical family member" was central to this discussion. The June 2006 HRSA Tribal Health Program Billing Instructions define a "clinical family member" able to receive mental health services as "A

[3] Chapter 3, page 119.

person who maintains a familial relationship with a Tribal member" and goes on to specify four family relationships centering on being either a spouse/partner, child in the care of an eligible Tribal member, woman pregnant with the child of an eligible Tribal member, or adult under the guardianship of an eligible Tribal member.

Focus group participants talked about how Tribes such as the Stillaguamish Tribe take an expanded view of people for whom the Tribe is responsible to provide health care. This was expressed as both a duty to others, as well as a pragmatic concern to address the health care needs of people living on or near Tribal land, particularly in the case of Tribes whose land is in multiple parcels that are sometimes separated by non-Tribal land. Some participants suggested that the reference to a "familial relationship" in the first section of the definition of a "clinical family member" could be viewed within the cultural context of some Tribes to include a wider range of relationships beyond those more specifically defined.

The Washington requirements focus on the rights of Tribal members and, by extension, their family members as a way to offer guidance in these matters. Both New Mexico and Arizona take a different approach, addressing this issue by defining both the rights of Tribal members to receive services and the rights of Tribal providers either to participate in Medicaid managed care networks operated by a statewide entity (New Mexico) or Tribal managed care organizations (Arizona). If Washington were to clarify the basis on which Tribal providers may participate in RSN networks, those providers would be available to serve both Tribal members and others eligible for service under that authority.

Specific best practices of interest to Tribal representatives. Focus group participants noted a range of practices that they would like to see better incorporated into Washington's mental health benefit design. Much of the discussion centered on traditional medicine, the specific traditional healing practices developed over time by each of the State's 29 recognized Tribes. While commonalities across Tribes are sometimes noted, focus group representatives underscored that each Tribe's practices are distinct, reflecting their independent cultures and histories. In discussing these practices, several focus group participants noted that different cultures value different types of evidence for the effectiveness of health services, and that community recognition of the value of a practice was at least as important (and in some cases more so) to Tribes as the scientific evidence more commonly cited in discussions of evidence-based practices within Washington's mental health system.

While focus group participants were interested in expanding access to traditional healing services, they also noted the risks of "medicalizing" traditional healing approaches if they are made subject to the regulatory requirements of specific funding sources, particularly Medicaid. Participants also seemed clear that an encounter-based reimbursement system did not seem to be a good fit for funding such services.

Arizona has developed an encounter-based system for reimbursing traditional health practices. Their July 2007 Covered Behavioral Health Services Guide defines H0046 Mental Health Services NOS (formerly Traditional Healing Services) as "Treatment services for mental health or substance abuse problems provided by qualified traditional healers. These services

include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability." These services are reported in 15 minute increments and are paid for only by State funds (not Medicaid). Arizona also defines a provider type for this service of Tribal Traditional Service Practitioner.

New Mexico requires its statewide managed care organization (known as the "Statewide Entity" or "SE") to make available a range of traditional healing services: "The SE shall ensure that alternative/ traditional healing services (i.e., traditional healers, sweat lodges, ceremonies, acupuncture, etc.) provided through Native American programs continue and/or are developed as appropriate."[4]

Despite their concerns about the process for doing so, focus group participants were generally desirous of the development of a framework through which traditional healing practices would be formally included, defined, and reimbursed within Washington's public mental health benefit. There was also clear guidance from both focus groups that such a benefit be carefully developed through consultation with all of Washington's 29 recognized Tribes. Both focus groups also recommended that a formal study of traditional healing practices in Washington State be carried out in support of developing such a benefit.

Access to traditional medicine can be supported through both involvement of traditional practitioners and support of specific traditional practices. While the inclusion of specific traditional practices in Washington's mental health benefit would require the process of comprehensive input and involvement described above, better involvement of Tribal providers could in and of itself also help promote access to traditional healing practices integrated within Tribal medical settings. Wider involvement of Tribal provider facilities in RSN networks or independently would offer one route.

The role of Native American Ethnic Minority Mental Health Specialists (EMMHS) was also discussed. Focus group participants were generally negative toward the current implementation of the EMMHS model for Tribal members, primarily because these specialists are seen as part of the CMHA and RSN systems and therefore viewed as not well integrated into the Tribal provider system. This seemed to be in large part related to the barriers to Tribal provider participation noted earlier in this chapter. If these previously noted barriers are addressed, it may be that the EMMHS designation could serve as a basis for developing traditional healing services as part of the mental health benefit. However, currently the EMMHS designation does not include criteria for specialization for specific ethnic minority groups. Development of such criteria for Native American traditional healing practices within specific Tribal communities might make the EMMHS designation more effective in promoting traditional healing services, but would also require comprehensive involvement and participation from all 29 Tribes.

Several focus group participants noted that the process for designating providers as qualified traditional healers should be less a process of conforming to written criteria than a process

[4] 2007 State of New Mexico Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract, Section 3.16.R.

whereby a Tribal community formally recognizes traditional healers through its own traditional processes. Recognizing the need for Tribes to designate their own traditional healers in accord with established custom was a central theme articulated in the focus groups.

In addition to improving access to traditional healing practices, focus group participants also underscored the importance of the following best practices for Tribal members:

- Integrated substance abuse and mental health services,
- Mental health services integrated within primary care and other human service settings, and
- Improved outreach to Tribal members in need, particularly in eastern Washington areas where providers are often located long distances from Tribal members and others in need.

Integrated mental health services with substance abuse services and primary care services were among the top five priorities for statewide system development. Tribal focus group participants also underscored the need for start-up funding to pay for training and infrastructure for providers adopting evidence-based integrated practices. These concerns echoed those noted for the broader mental health system. Focus group participants emphasized that Tribal providers need to be involved in broader system initiatives to promote evidence-based and other best practices, with opportunities for input into how these practices need to be modified in their requirements (either administrative or clinical) so as to ensure their availability and responsiveness to the needs and strengths of Tribal members.

Need for better tracking of Tribal membership status in mental health information systems. Focus group participants and key informants noted that the current mental health encounter tracking system through RSNs does not adequately document the range of services delivered to Tribal Members. Participants noted that Tribal membership status is not systematically tracked across RSNs, observing that DASA seems to do a better job of such tracking. They specifically observed the need for data systems to include specific fields to collect data on Tribal membership status and requirements for RSNs and providers to routinely collect such data. This data would be collected in addition to information on race and ethnicity. Any person identifying as a Native American would also be asked about their Tribal membership status.

Importance of direct coordination between Tribal governments and MHD. Focus group participants discussed a range of concerns related to the current level of coordination between MHD and Tribal Governments. Participants discussed an overall sense that rules are used "to say no" rather than to identify ways to move forward. This seemed related to a perception that communication and decision-making has been problematic across multiple issues. Some of this concern seemed to relate to issues with specific RSNs. While some Tribes were very positive about their collaboration with RSNs, others were not. Currently, most coordination of services seems to be expected to happen between RSNs and the Tribes in their geographic areas, so variability across these many relationships seems inevitable. Focus group participants therefore noted the need for coordination directly with MHD to offer Tribes a direct path to "government-to-government" coordination and to provide a more reliable guide for individual RSN coordination efforts.

Participants observed that important steps have already been taken to improve direct communication with MHD, and they were uniformly positive about the current Tribal Billing Instructions and Tribal Mental Health Work Group meetings, which in 2007 are occurring more consistently than in the previous year. However, participants noted the desire for MHD to identify a senior managerial staff member (or members) who would be able to serve as a single point of responsibility for addressing policy questions related to benefits and other matters of importance to Tribes. One person could carry out this role or the role could be differentiated across policy areas (e.g., network participation, billing, involuntary treatment). This staff position would involve more than what participants perceived the current Tribal Liaison position to entail, in that the position would be a senior manager (preferably full time and reporting directly to the MHD Division Director) with authority to convene needed DSHS staff to develop definitive policy guidance in response to issues that arise.

While these specific ideas were offered, it appeared that the concern underlying these suggestions involved a need for "government-to-government" forums between senior MHD representatives and Tribal governments. MHD subcontractors (such as RSNs) and mid-level managers (such as Tribal Liaisons) can provide important coordination activities, but participants were clear that regular forums that included the involvement of senior MHD staff were also needed.

Related to this was an additional need to more clearly differentiate between formal policy consultation subject to the communication requirements of the 7.01 process and less formal gathering and sharing of information to inform the development of policy. It seemed clear that participants valued the communication requirements surrounding formal policy consultation, but also desired more timely and less cumbersome processes for (1) communication and clarification of current policy and (2) information gathering for future policy development. It may be that the reinstituted Mental Health Work Group and Tribal Billing Instructions meetings may offer such forums, but there seemed to be a need to articulate criteria for when the deliberations of these groups were subject to formal review under 7.01.

Recommendations

All of the issues expressed in the focus groups and discussed above are important issues at the heart of MHD's relationship with each of Washington's 29 federally-recognized Tribes, and these issues also directly affect the availability and quality of care for Tribal members and other Native Americans across the State. Given this, MHD should review all of these issues so that they can inform efforts to coordinate services for Tribal members in all relevant venues with Tribes, including both statewide forums such as the Mental Health Work Group and RSN-specific efforts.

In addition to this, we offer the following specific recommendations for additional consideration and implementation by MHD. These recommendations have been developed with consideration of the broader recommendations in the chapter on "Mental Health

Transformation in Collaboration with Indian Country" offered through the 2006 Washington Mental Health Transformation Plan: Phase 1.[5] Our recommendations include:

- **Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.** Given the complexity of Tribal mental health systems, MHD risks continuing confusion, frustration, and barriers to care if all 13 RSNs are left to conduct their relationships with Tribal governments and providers without additional guidance. We recommend that a handbook for RSNs be developed that lays out in one place the requirements to guide these RSN interactions. The handbook should describe the multiple choices that Tribes and Tribal members have for accessing mental health services and the role of the RSN within that. In addition, it should describe the rights that Tribes have to make choices in how they involve RSNs in the mental health care of their members. It should also incorporate guidance on the involvement of Tribal providers in RSN networks, as well as Tribal members in the provision of care, including clinical family members.
- **Develop a clear policy for the involvement of IHS and 638 facility providers in 1915-B waiver networks.** Federal rules (42 CFR 431.110) stipulate that states may not exclude IHS providers from their Medicaid systems. While Washington is in compliance with this requirement by offering IHS and Tribal 638 facilities access to encounter-based fee for service reimbursement, it does not ensure the involvement of these providers in its 1915-B waiver network, either through RSN networks or through direct relationships with Tribes similar to those developed in Arizona for Tribal RHBAs. At a minimum, we recommend that willing IHS and Tribal 638 facilities able to comply substantially with RSN credentialing requirements be allowed to participate in RSN networks without CMHA licensure. We further recommend that RSNs be required to provide technical assistance to IHS and Tribal 638 facilities that desire to participate in their networks, but that are not yet able to comply with credentialing requirements. Regulations by MHD to enact these recommendations should be developed with the involvement of Tribal governments, Tribal providers, RAIOs, and RSNs. Such requirements are likely to increase the administrative costs to RSNs to administer their networks and provide technical assistance to providers, so consideration of this should be factored into the administrative component of rate setting. As part of this effort, MHD should consider whether it makes sense to convene a work group to explore mechanisms for direct contracting with Tribes. Consultation with the federal Center for Medicare and Medicaid Services (CMS) should also be undertaken to determine if modifications of the 1915-b waiver similar to those incorporated by New Mexico are needed, or if existing federal statutes (e.g., 42 CFR 431.110) offer sufficient authority without modification of the waiver.
- **Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.** Many ideas were offered in the focus groups and discussed above about how to define such a benefit, but definitive guidance in this area is beyond the expertise of the authors of this chapter. Therefore, we recommend that MHD work through the Tribal Mental Health Work Group in collaboration with all 29 federally-recognized Tribes to convene a work group to study the traditional healing practices of all of Washington's

[5] Chapter 3, pages 116 to 121.

29 federally-recognized Tribes. This study should draw on the guidance of best practice sources such as the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center.[6]

- **Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.** As MHD develops initiatives in response to the broader recommendations of the final benefit design report, specific provisions to ensure the inclusion of Tribes should be included. Furthermore, Tribal representatives expressed particular interest in the development of integrated mental health / substance abuse services and integrated mental health / primary care services, and Tribal input should be sought in the design of any initiatives to promote such services.
- **Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.** It was the clear preference of focus group participants that these forums continue and that the level of MHD representation should be senior enough to respond definitively to the complex issues involved in coordinating mental health services across 29 distinct Tribes. We recommend that MHD continue these meetings on a monthly basis and designate at least one senior staff member reporting to the Division Director to consistently attend these meetings. These meetings will also offer a forum for addressing other important issues raised in this chapter and in other forums, such as the need to develop information system supports sufficient to track Tribal member service use.

[6] http://aianp.uchsc.edu/ncaianmhr/ncaianmhr_index.htm